PATIENT INFORMATION **WILLIAM S. BURKES, M.D.**

NAME: _____ SS#:_____
ADDRESS: _____
CITY: _____ STATE/ZIP CODE: _____
DATE OF BIRTH_____ SEX: M_____F_____ MARITAL STATUS:_____
PHONE: _____ SPOUSE: _____
PRIMARY PHYSICIAN: _____ PHONE: _____
REFERRING PHYSICIAN: _____ PHONE: _____

EMPLOYER INFORMATION
EMPLOYER:_____
ADDRESS: _____
CITY: _____ STATE/ZIP: _____
PHONE: _____ OCCUPATION: _____

SELF PAY:_____ MEDICARE: _____ MEDICAID: _____ COMM:_____ WORK/COMP: _____

PRIMARY INSURANCE

INSURANCE: _____
ADDRESS: _____
CITY: _____ STATE/ZIP: _____
INSURED NAME: _____ DATE OF BIRTH: _____
POLICY/SS#: _____ CLAIM/GROUP#: _____
TWCC #: _____ DATE OF INJURY: _____
IS INJURY WORK RELATED? _____ AUTO ACCIDENT? _____

SECONDARY INSURANCE
CARRIER: _____ ADJUSTOR: _____
ADDRESS: _____
CITY: _____ STATE/ZIP: _____
CLAIM/GROUP #: _____ POLICY/SS#: _____

EMERGENCY CONTACT
NAME:_____ RELATION: _____
ADDRESS _____ CITY: _____
STATE/ZIP: _____ PHONE: _____

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS INCLUDING BY ELECTRONIC MEANS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO WILLIAM S. BURKES, M.D. FOR CHARGES FILED ON MY PERSONAL INSURANCE AND WILL PAY FOR ANY CHARGES NOT COVERED BY MY INSURANCE PLAN. WORKER'S COMPENSATION CLAIMS ARE EXCLUDED FROM FINANCIAL RESPONSIBILITY.

SIGNATURE:_____ DATE: _____